DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

RESIDENT RECORD CHECKLIST – RESIDENTIAL CARE CENTERS FOR CHILDREN AND YOUTH

Use of form: Use of this form is voluntary. However, use as a review document by residential care centers will help ensure compliance with DCF 52.49(2)(a) and (b). Licensing specialists may also use this form during monitoring visits to document compliance with these rules. Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: A check mark indicates the required information is in the file. **Licensing specialist:** Monitoring activity standards are 10% of all active files or a minimum of 3 to 5 active files and at least 3 closed files over the 2-year licensing period.

Name – Facility			Facility ID Number	
___ of ___ Records Reviewed (Total Number of Records Reviewed / Total Number of Records)	**RESIDENT NO. 1**	**RESIDENT NO. 2**	**RESIDENT NO. 3**	**RESIDENT NO. 4**
GENERAL INFORMATION				
1. Name				
2. Birthdate				
3. Placement date				
4. Referral source				
5. Gender				
6. Race				
7. Religion				
8. Birthplace				
9. Name, address, telephone number of parent, guardian, legal custodian at time of admission				
10. Documentation of current court status if applicable				
11. Current custody and guardianship arrangements				
12. Restitution plan if applicable				
13. Recent photo of resident [52.49(2)(k)]				
TREATMENT RECORD 52.49(2)(b)1.				
1. History of resident and resident's family 52.49(2)(b)1.a.				
2. Admission Screening Report 52.49(2)(b)1.b.; 52.21(2)				
3. Needs Assessment and Treatment Plan 52.49(2)(b)1.c.; 52.22(2)(c)1.				
4. Documentation that a copy of the treatment plan has been provided to the placing person or agency 52.22(2)(c)2.				
5. Assessment by a resident services case manager of the resident's progress in response to treatment 52.22(3)(a)1.				
6. Documentation by a resident services case manager of significant events relating to implementation of the resident's treatment plan 52.22(3)(a)2.				
7. Documentation of treatment plan reviews at least once every 3 months for progress being made toward meeting the goals described in the treatment plan 52.22(3)(b)1.				
8. Documentation of treatment plan reviews as necessary, consistent with treatment plan goals and permanency planning goals of the placing person or agency 52.22(3)(b)2.				
9. Written progress reports to the placing person or agency from each external professional service provider regarding the resident's progress 52.12(8)(a)3.				
10. Written notification to the placing person or agency of all recommendations made by the specialist or consultant for the resident 52.12(8)(b)				
11. Aftercare plan prepared in writing at least 30 days before the planned discharge of the resident 52.23(1)(b)				
12. Discharge summary required within 30 days following discharge 52.23(3)				
13. Documentation of denial of resident rights and copies of grievances and responses to them 52.49(2)(i)				

	RULE	RESIDENT NO. 1	RESIDENT NO. 2	RESIDENT NO. 3	RESIDENT NO. 4
14.	Incident reports – significant incidents 52.41(1)(a)10.; 52.49(2)(j)				
15.	Incident reports – physical hold restraint or physically enforced separation 52.41(6)(c); 52.49(2)(j)				
16.	Report of child abuse or neglect under s. HFS 52.12(9); 52.49(2)(L)				
17.	Written report when staff use mechanical restraints to take a Type 2 resident into physical custody.				
18.	Written acknowledgement that a Type 2 resident has received notification of rules, consequences, and procedures.				
HEALTH RECORD 52.45(4); 52.46; 52.49(2)(b)2.					
1.	Dates and results of all physical health, mental health and dental exams 52.45(4)(b)				
2.	Health history and, if applicable, medications history prior to admission and during the resident's stay at the center 52.45(4)(c)				
3.	Immunizations received while resident of the center 52.45(4)(d)1.				
4.	Laboratory tests received while resident of the center 52.45(4)(d)2.				
5.	Routine health care exams and treatment received while resident of the center 52.45(4)(d)3.				
6.	Emergency health care exams and treatment received while resident of the center 52.45(4)(d)4.				
7.	Dental exams and treatment received while resident of the center 52.45(4)(d)5.				
8.	The written over-the-counter medications administration record 52.45(4)(e); 52.46(4)(a)1.				
9.	The written prescription medications administration record 52.45(4)(e); 52.46(4)(a)2.				
10.	Documentation about any special nutritional or dietary needs identified by a physician or dietician and a copy of the nutritional care plan approved by a registered dietitian 52.44(2)(c); 52.45(4)(f); 52.49(2)(b)2.c.				
11.	Information about any health allergies or health-related restrictions 52.46(2)(a)1.				
12.	.Documentation of physical or mental changes that have occurred from a medication 52.46(2)(b)4.				
13.	Documentation of review by the resident's physician or center medical consultant when there are noted adverse effects from a medication 52.46(2)(b)6.				
14.	Written report from the prescribing physician obtained at least within the first 45 days after the resident has first received a psychotropic medication and at least every 60 days thereafter 52.46(5)(c)3.				
15.	The physician's reasons for ordering emergency administration of psychotropic medication 52.46(5)(d)5.				
16.	Documentation of revocation of consent for non-emergency use of psychotropic medications 52.46(5)(e)2.b.				
17.	Statement of resident refusal to take a prescribed psychotropic medication signed by 2 staff members who personally witnessed the refusal 52.46(5)(e)3.a.				
EDUCATIONAL RECORD 52.43(5); 52.49(2)(b)3.					
1.	Results of educational assessments 52.43(5)				
2.	Educational goals 52.43(5)				
3.	Progress reports 52.43(5)				
4.	Any records of vocational training or employment experiences 52.49(2)(b)4.f.				
INTERSTATE COMPACT FOR THE PLACEMENT OF CHILDREN (ICPC)					
1.	Written prior approval under the interstate compact on the placement of children under s. 48.988, Stats.				
2.	Information on the resident's social, medical and educational history				
INFORMED CONSENT					
1.	Written consent for locked unit use signed by the parent or guardian and legal custodian of the resident if a minor, or a copy of the locked unit intervention ordered by a court or other lawful authority 52.42(7)(a)3.d.				

	RULE	RESIDENT NO. 1	RESIDENT NO. 2	RESIDENT NO. 3	RESIDENT NO. 4
2.	Authority to order or provide to the resident routine medical services and procedures, including scheduled immunizations and dental services and non-prescription and prescription medications 52.21(5)(a)1.				
3.	Authority to delegate and supervise administration of medications by center-authorized staff and for staff to handle and provide the medication to the resident and observe self-administration of the medication by the resident 52.21(5)(a)2.				
4.	Authority to obtain other medical information on the resident 52.21(5)(a)3.				
5.	Authority to provide or order when there is a life-threatening situation, emergency medical procedures, including surgery, when it is not possible to immediately reach the person or authority authorized to give signed written specific informed consent 52.21(5)(a)4.				
6.	Written consent to non-emergency use of psychotropic medications signed by the resident, if 14 years of age or older, and the resident's parent or guardian and legal custodian 52.46(5)(c)2				
7.	Written informed consent for emergency administration of a psychotropic medication from the resident's parent or guardian and legal custodian, if any, and from the resident if 14 years of age or older 52.46(5)(d)2.				
8.	If written informed consent was not obtained before administration of psychotropic medication, documentation of notification of the parent or guardian and legal custodian, if any, as soon as possible following emergency administration 52.46(5)(d)4.				

Any informed consent document shall include declaration that the patient or the person acting on the patient's behalf has been provided with: 94.03(1)

- Specific, complete and accurate information concerning the proposed treatment or services 94.03(1)
- Time to study the information or to seek additional information concerning the proposed treatment or services 94.03(1)
- The benefits of the proposed treatment and services 94.03(1)(a)
- The way the treatment is to be administered and the services are to be provided 94.03(1)(b)
- The expected treatment side effects or risks of side effects which are a reasonable possibility, including side effects or risks of side effects from medications 94.03(1)(c)
- Alternative treatment modes and services 94.03(1)(d)
- The probable consequences of not receiving the proposed treatment and services 94.03(1)(e)
- The time period for which the informed consent is effective, which shall be no longer than 15 months from the time the consent is given 94.03(1)(f)
- The right to withdraw informed consent at any time, in writing 94.03(1)(g)

The subject patient who has signed the informed consent document must be competent or the consent form shall be signed by the legal guardian of an incompetent patient or the parent of a minor. Note: patient's informed consent is always required for the patient's participation in experimental research, subjection to drastic treatment procedures or receipt of electroconvulsive therapy 94.03(2)

Emergency oral consent shall be replaced by written informed consent within 10 days 94.03(2m)

Name – Licensing Specialist	Date Signed (mm/dd/yyyy)